**National Provider Identifier (NPI)**
**March 2007 Seminar Registration Form**
*(No Fee)*

National Provider Identifier

Provider Name_____

Medicaid Provider Number_____NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____E-mail_____

Telephone Number(____)_____Fax Number_____

**1** or **2** person(s) will attend the seminar at _____on_____
(circle one) (location) (date)

**Please fax completed form to: 919-851-4014**
**Please mail completed form to:**
**EDS Provider Services**
**P.O. Box 300009**
**Raleigh, NC 27622**